

Case Number:	CM13-0034089		
Date Assigned:	01/03/2014	Date of Injury:	01/07/2011
Decision Date:	05/16/2014	UR Denial Date:	10/01/2013
Priority:	Standard	Application Received:	10/11/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Orthopedic Surgery, and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 54-year-old female who reported an injury on 03/01/2009, secondary to repetitive lifting. Current diagnoses include spinal stenosis of the lumbar region, recurrent stenosis at L5-S1, and recurrent disc herniation at L5-S1. The injured worker was evaluated on 09/23/2013. The injured worker reported 5/10 pain in the cervical spine as well as 8/10 pain in the lower back with radiation to the left lower extremity. Prior conservative treatment was not mentioned. Physical examination revealed 5/5 motor strength in bilateral lower extremities with the exception of the left EHL, decreased sensation to light touch in the dorsum of the foot on the left side, and absent Achilles reflex on the left. Treatment recommendations at that time included an anterior spinal interbody fusion with lumbar laminectomy and decompression.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

LUMBAR LAMINECTOMY AND DECOMPRESSION L5-S1 WITH FUSION: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 305-306.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307. Decision based on Non-MTUS Citation Official Disability Guidelines.

Decision rationale: The ACOEM Guidelines state surgical consultation is indicated for patients who have severe and disabling lower extremity symptoms, activity limitation for more than 1

month, extreme progression of lower extremity symptoms, clear clinical, imaging and electrophysiological evidence of a lesion, and failure of conservative treatment. The Official Disability Guidelines state prior to a discectomy and laminectomy, there should be evidence of radiculopathy upon physical examination. Imaging studies should indicate nerve root compression, lateral disc rupture, or lateral recess stenosis. Conservative treatments should include activity modification, drug therapy, and epidural steroid injections. There should also be a referral for physical therapy, manual therapy, or psychological testing. Prior to a spinal fusion, there should be Final Determination Letter for IMR Case Number [REDACTED] identification and treatment of all pain generators, completion of physical and manual therapy, evidence of spinal instability upon x-ray, CT myelogram, or discography, limitation to no more than 2 levels and a psychological screening with confounding issues addressed. As per the documentation submitted, the injured worker's physical examination does reveal decreased strength on the left, decreased sensation on the left, and absent Achilles reflex on the left. However, there is no mention of an exhaustion of conservative treatment. There is no evidence of a referral to physical therapy, manual therapy or completion of a psychological evaluation. There is no evidence of documented instability on flexion and extension view radiographs. Based on the aforementioned points, the injured worker does not meet criteria for the requested surgical procedure. As such, the request is not medically necessary and appropriate.

POST-OPERATIVE PHYSICAL THERAPY TWELVE SESSIONS: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

DURABLE MEDICAL EQUIPMENT 3:1 COMMUNE, LUMBAR BRACE, WALKER: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

HOME HEALTH CARE: 2 HOURS A DAY, SIX DAYS A WEEK FOR TWO WEEKS: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

TRANSPORTATION FOR ADLS AND TO/FROM MEDICAL APPTS: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

ASSISTANT SURGEON: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

LENGTH OF STAY: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

PRE-OP MEDICAL CLEARANCE: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.